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8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. *2013 - 248*

13 **GRACE MADARANG TATLONGHARI**
14 **23024 Atmore Avenue**
15 **Carson, CA 90745**

A C C U S A T I O N

16 **Registered Nurse License No. 657140**

17 **Respondent.**

18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
21 official capacity as the Executive Officer of the Board of Registered Nursing (Board),
22 Department of Consumer Affairs.

23 2. On or about May 3, 2005, the Board issued Registered Nurse License Number
24 657140 to Grace Madarang Tatlonghari (Respondent). The Registered Nurse License was in full
25 force and effect at all times relevant to the charges brought herein and will expire on December
26 31, 2012, unless renewed.

27 **JURISDICTION**

28 3. This Accusation is brought before the Board under the authority of the following
laws. All section references are to the Business and Professions Code (Code) unless otherwise
indicated.

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PATIENT BV

9. On or about January 21, 2007, at about 1300 hours, 67 year-old Patient BV was admitted to the Emergency Department (ED) at the Southern California Permanente Medical Group (SCPMG) with chills and weakness. Patient BV had a history of diabetes, hypertension, coronary artery disease, end-stage renal disease on dialysis and peripheral vascular disease. While in the ED, a triple lumen catheter was inserted in his right femoral artery. At 1323 hours, lab results show that Patient BV's hemoglobin level was 11.1. The ED physician orders state that Patient BV's platelet count was to be kept above 50,000. The patient was receiving multiple anticoagulant medications including Heparin and Integrilin drip, as well as Plavix and Aspirin. There was no mention of bleeding from the catheter site in the ED notes.

10. At 2130 hours, Patient BV was transferred to SCPMG's Step Down Unit where Respondent was working as a registered nurse and assigned to care for Patient BV. Respondent documented in the Adult Initial Assessment form at 2130 hours that Patient BV was "awake, A/O x4 ... pt denies chest pain ... Heparin & Integrilin infusing into R wrist IV access..." She also described the triple lumen catheter on the right groin as showing a "small amount of blood".

11. At 2300 hours, Respondent documented in the Multidisciplinary Progress Notes that she noted the patient to have "large amount of blood oozing from the central site (R groin)...IOD (Dr. Zukotynski) notified. Ordered to place pressure dressing over central line site. Bleeding decreased. Will continue to monitor closely."

12. At 2315 hours, lab results show that Patient BV's hemoglobin level was 9.4.

13. At 0030 hours on January 22, 2007, Respondent documented: "Pt sleeping but easily arousable...Rx notified & ordered to [decrease] Heparin...oozing of blood from central line site continued. IOD (Dr. Zukotynski) notified and ordered to keep pressure on the bleeding site...IOD made aware of drop from 11.0 Hgb [hemoglobin] to 9.4 . Will continue to monitor."

14. At 0210 hours, a physician ordered "decrease Heparin drip..."

15. At 0210 hours, lab results show that Patient BV's hemoglobin level was 9.0.

16. At 0400 hours, Respondent documented: "Pt is sleeping but easily arousable...BP currently 99/54, HR - 71, 100% O2 sat...A central line site continues to bleed when pressure is

1 released... Pt Hgb now 9.0. IOD (Dr. Zukotynski) notified [with] order to hold/stop Integrilin &
2 Heparin...IOD notified about [decrease] in Hgb...call IOD if Hgb is below 9.0. Will continue to
3 monitor pt."

4 17. At 0415, Dr. Zukotynski documented: "IOD called for bleeding at femoral vein
5 catheter site. At this time Integrilin and Heparin will be d/c. Hgb/Hct will be rechecked." Dr.
6 Zukotynski ordered "Repeat Hgb/Hct in one hour. Page MD [with] results. Type and Screen 2
7 units of PRBC. Hold Integrilin and heparin."

8 18. At 0530 hours, Respondent documented: "Pt sleeping, slow to arouse but able to
9 state name, place...Pt noted to have hematoma on R groin. IOD notified (Dr. Cheung) & stated
10 she will come and assess the pt. Will continue to monitor pt closely."

11 19. At 0544 hours, Respondent documented: "Pt now non-responsive even to painful
12 stimuli...B/P: 59/23, HR: 106. IOD notified [with] new orders, given & carried out. IOD (Dr.
13 Cheung) on the floor assessing pt – will monitor closely."

14 20. At 0600 hours, Dr. Cheung documented: "IOD called for ALOC...Integrilin/Hep
15 D/C'd 4 am for femoral cath site hemotoma. Pt obtunded....Extr large hemotoma R groin...."

16 21. At 0620 hours, Respondent documented: "Pt still non-responsive. B/P: 51/29, HR:
17 106. Pt given NS [normal saline] 1000 ml bolus. TLC [triple lumen catheter] inserted into L
18 femoral inserted by Dr. Fane. Will monitor pt."

19 22. At 0622 hours, Respondent documented: "...unable to take pt's B/P. Dopamine drip
20 started at 5mcg/kg/min. Dr. Cheung at the bedside."

21 23. At 0624 hours, Respondent documented: "Pt still [with] no B/P, still unresponsive.
22 Code Blue called."

23 24. At 0626 hours, Patient BV expired.

24 25. At 0650 hours, lab results show that Patient BV's hemoglobin level was 5.6.

25 26. The Certificate of Death lists as Cause of Death the following:

26 Acute Myocardial Infarction
27 Hematoma Bleed from Anticoagulant
28 End Stage Renal Disease

1 **CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct: Gross Negligence)**

3 27. Respondent is subject to disciplinary action under Code section 2761, subdivision
4 (a)(1), in conjunction with California Code of Regulations, title 16, section 1442, in that on
5 January 21-22, 2007, Respondent was grossly negligent in her care of Patient BV. The
6 circumstances are as alleged in paragraphs 9-26 which are incorporated herein by reference, and
7 as follows:

8 a. Respondent failed to provide continuous monitoring of Patient BV. Respondent
9 failed to initiate more frequent records of the patient's vital signs and the condition of the
10 bleeding site, and to provide pressure on the bleeding site. There were no nursing notes recorded
11 from 0030 hours to 0400 hours on January 22, 2007.

12 b. Respondent failed to immediately intervene to protect the safety of her patient or to
13 notify her supervisor of the patient's condition. Although Respondent documented she notified of
14 the physician of Patient BV's situation, the physician did not discontinue Integrilin and Heparin
15 until 0400 hours on January 22, 2007.

16 **PRAYER**

17 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
18 and that following the hearing, the Board of Registered Nursing issue a decision:

19 1. Revoking or suspending Registered Nurse License Number 657140, issued to Grace
20 Madarang Tatlonghari;

21 2. Ordering Grace Madarang Tatlonghari to pay the Board of Registered Nursing the
22 reasonable costs of the investigation and enforcement of this case, pursuant to Business and
23 Professions Code section 125.3;

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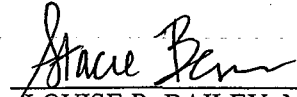
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3. Taking such other and further action as deemed necessary and proper.

DATED: OCTOBER 09, 2012

for 
LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

LA2012507264